Substitute per letter dated 4/7/00

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after July 1, 1992, the Department pays for outpatient hospital and emergency services with a rate which is the product of -

1. Eighty-five percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form HCFA-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on Form HCFA-1450 (UB-82).

The effective date of the cost-to-charges percentage is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on Form HCFA-1450 (UB-82) in a summary bill format. Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services on the fee schedule determined by HCFA.

Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 1999, payment for outpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. NMAP will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made in accordance with reasonable cost principles. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, NMAP will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

Transmittal MS-99-09

Supercedes Approved MAY 04 2000 Effective OCT 01 1999

Transmittal MS-92-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to Medicare methods.

Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for a medical emergency, accident, or injury (see definition of medical emergency in 471 NAC 10-001.02);

2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by a physician such as for allergy shots or when traveling (a written referral by the physician must be attached to the claim);

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly.
When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charges. All other Medicaid allowable charges incurred in this type of visit will be paid at 85% of the ratio of cost-to-charges.

Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as stat fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

Payment to a New Hospital for Outpatient Services: See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (a new operational facility) will be made at 85% of the statewide average ratio of cost to charges for Nebraska hospitals as of July 1 of that year as determined by the Department. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department using 85% of the statewide average ratio of cost to charges. The cost settlement will be the lower of cost or charges as reflected on the hospital's cost report (i.e., the Department's payment must not exceed the upper limit of the provider's charges for services).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 ff.)

Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges times 85% for all Nebraska hospitals for that fiscal year as of July 1 of that year.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

RURAL HEALTH CLINICS

NMAP pays for RHC services provided by provider-based RHC's at the lower of cost or charges as established by Medicare. For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with departments of the facility.

NMAP pays for RHC services provided by independent RHC's at the reasonable cost rate per visit as established by Medicare. For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

Independent Rural Health Clinics (IRHC's) will be reimbursed according to the Nebraska Medicaid Practitioner Fee Schedule for services rendered. At an interval yet to be determined (annually, semiannually, or quarterly), a cost settlement will be calculated for each IRHC by multiplying its Medicare approved Encounter Rate by the number of encounters (all services per recipient per day equals one encounter) and comparing the result to the total amount paid for services during the cost settlement period. The difference will then be paid to or collected from the IRHC as a cost settlement.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

RURAL HEALTH CLINICS

NMAP pays for Rural Health Clinic (RHC) services provided by provider-based RHCs associated with hospitals of 50 beds or more at the reasonable cost rate per visit as established by Medicare. NMAP pays for RHC services provided by provider-based clinics associated with hospitals under 50 beds at the lower of cost or charges, as established by Medicare. For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

A provider-based RHC is defined as an integral part of a hospital, nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with departments of the facility.

NMAP pays for RHC services provided by Independent RHCs at the reasonable cost rate per visit as established by Medicare. For those non-RHC services for which no charge has been established by Medicare, NMAP makes payment according to the Nebraska Medicaid Practitioners Fee Schedule.

The annual cost settlement will be calculated for each provider-based RHC associated with hospitals of 50 beds or more and Independent RHCs using the Medicare approved encounter rate multiplied by the number of encounters (all services per recipient per day is one encounter). This figure is compared to the total amount paid for services during the cost settlement period and facilities are paid the lower amount. Reimbursement for clinical laboratory and radiology services is included in the encounter rate.

"Substitute per letter dated 07/13/90"

ATTACHMENT 4.19-B
Item 2c

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

FEDERALLY-QUALIFIED HEALTH CENTERS

The Nebraska Medical Assistance Program (NMAP) makes payment for services provided by federally-qualified health centers (FHQC's) as defined in section 1905(a)(2)(C) of the Social Security Act on the basis of 100 percent of reasonable costs attributed to the care of Medicaid-eligible clients, as established by the Nebraska Department of Social Services.

Reasonable costs are determined by the Department on the basis of the FQHC's cost report, submitted as the Medicare cost report (Form HCFA-2552) or any other cost reporting form approved by the Department for this use. Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles set forth in 42 CFR Part 413.

Providers participating in the NMAP as FQHC's must submit to the Department a plan for allocating costs to the Medicaid program. This plan must also indicate the annual cost reporting period by which the FQHC plans to report its annual costs to the Department.

The Department will make interim payments to the FQHC during its cost reporting period. The interim payments will be the amounts normally paid to the FQHC under the Nebraska Medicaid Practitioner Fee Schedule, and will be subject to reconciliation at the end of the cost reporting period. Following the receipt of the FQHC's annual Medicare cost report (or other acceptable cost reporting form), the Department will compute a retroactive adjustment to the annual allowable Medicaid costs as reported by the FQHC. The Department will make additional payment to the FQHC when the allowable reported annual Medicaid costs exceed the sum of the payments made to the FQHC under the Nebraska Medicaid Practitioner Fee Schedule for the cost reporting period. Payment adjustments will be made within 90 days of receipt of the cost report by the Department. The FQHC must reimburse the Department when its allowable reported Medicaid costs for the cost reporting period are less than the sum of the payments made to the FQHC under the Nebraska Medicaid Practitioner Fee Schedule for the cost reporting period. Adjustments owing to the Department must be made within 90 days following notice by the Department to the FQHC of the amount due and owing.

Nebraska has determined and assures that payments to FQHC's are based upon and cover the reasonable costs of providing services to Medicaid beneficiaries.

Transmittal # MS-90-12

Supercedes Approved 7/18/90 Effective 7/1/90

Transmittal # MS-90-5

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER LABORATORY AND X-RAY SERVICES

Anatomical Laboratory Services

For dates of service on or after August 1, 1989, NMAP pays for anatomical laboratory services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medical Services Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Clinical Diagnostic Laboratory Services

Payment for clinical diagnostic laboratory services is based on the Medicare national fee schedule for clinical laboratory services as established by HCFA to cover the total service (professional and technical components).

X-Ray Services

For dates of service on or after August 1, 1989, NMAP pays a claim for both the technical and professional components of x-ray services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule);
   c. The maximum allowable dollar amount; or
   d. The reasonable charge for the procedure as determined by the Medical Services Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

The Nebraska Medicaid Practitioner Fee Schedule is effective July 1 through June 30 of each year.

Revisions of the Fee Schedule: The Department reserves the right to adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in nationally-recognized coding systems, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medical Services Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

The Department may issue revisions of the Nebraska Medicaid Practitioner Fee Schedule during the year that it is effective. Providers will be notified of the revisions and their effective dates.

Payment for the professional component only provided to hospital inpatient or outpatient is made according to the Nebraska Medicaid Practitioner Fee Schedule, not to exceed 40 percent of the payment for the total component, as allowed under the fee schedule, for the service provided in a non-hospital setting.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

SKILLED NURSING FACILITIES

See Attachment 4.19-D

State Plan
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Supersedes MS 82-11
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